A burn is an injury to the skin or other organic tissue primarily caused by heat or due to radiation, radioactivity, electricity, friction or contact with chemicals. Thermal (heat) burns occur when some or all of the cells in the skin or other tissues are destroyed by:

- hot liquids (scalds)
- hot solids (contact burns), or
- flames (flame burns).

**Key facts**

- An estimated 180,000 deaths every year are caused by burns – the vast majority occur in low- and middle-income countries.
- Non-fatal burn injuries are a leading cause of morbidity.
- Burns occur mainly in the home and workplace.
- Burns are preventable.

**First aid**

Basic guidance on first aid for burns is provided below.

**What to do**

- Stop the burning process by removing clothing and irrigating the burns.
- Extinguish flames by allowing the patient to roll on the ground, or by applying a blanket, or by using water or other fire-extinguishing liquids.
- Use cool running water to reduce the temperature of the burn.
- In chemical burns, remove or dilute the chemical agent by irrigating with large volumes of water.
- Wrap the patient in a clean cloth or sheet and transport to the nearest appropriate facility for medical care.

**What not to do**

- Do not start first aid before ensuring your own safety (switch off electrical current, wear gloves for chemicals etc.)
- Do not apply paste, oil, haldi (turmeric) or raw cotton to the burn.
- Do not apply ice because it deepens the injury.
- Avoid prolonged cooling with water because it will lead to hypothermia.
- Do not open blisters until topical antimicrobials can be applied, such as by a health-care provider.
- Do not apply any material directly to the wound as it might become infected.
- Avoid application of topical medication until the patient has been placed under appropriate medical care.

Source: [https://www.who.int/news-room/fact-sheets/detail/burns](https://www.who.int/news-room/fact-sheets/detail/burns)
A syndromic surveillance system is good for early detection of and response to public health events.

Sentinel surveillance occurs when selected health facilities (sentinel sites) form a network that reports on certain health conditions on a regular basis, for example, weekly. Reporting is mandatory whether or not there are cases to report.

Jamaica’s sentinel surveillance system concentrates on visits to sentinel sites for health events and syndromes of national importance which are reported weekly (see pages 2 - 4). There are seventy-eight (78) reporting sentinel sites (hospitals and health centres) across Jamaica.

Sentinel surveillance in Jamaica

Map representing the Timeliness of Weekly Sentinel Surveillance Parish Reports for the Four Most Recent Epidemiological Weeks - Weeks 44 to 47

Parish health departments submit reports weekly by 3 p.m. on Tuesdays. Reports submitted after 3 p.m. are considered late.

Reports for Syndromic Surveillance

FEVER
Temperature of >38°C /100.4°F (or recent history of fever) with or without an obvious diagnosis or focus of infection.

KEY
VARIATIONS OF BLUE SHOW CURRENT WEEK
**FEVER AND NEUROLOGICAL**
Temperature of >38°C / 100.4°F (or recent history of fever) in a previously healthy person with or without headache and vomiting. The person must also have meningeal irritation, convulsions, altered consciousness, altered sensory manifestations or paralysis (except AFP).

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**FEVER AND HAEMORRHAGIC**
Temperature of >38°C / 100.4°F (or recent history of fever) in a previously healthy person presenting with at least one haemorrhagic (bleeding) manifestation with or without jaundice. Visits for Fever and Haemorrhagic symptoms were reported in weeks 4 to 8, 39, 41, 42, 44 and 46 year to date.

---

**FEVER AND JAUNDICE**
Temperature of >38°C /100.4°F (or recent history of fever) in a previously healthy person presenting with jaundice.

The epidemic threshold is used to confirm the emergence of an epidemic in order to implement control measures. It is calculated using the mean reported cases per week plus 2 standard deviations. Visits to sentinel sites for Fever and Jaundice were reported in weeks 7, 10, 33, 43 and 47 only, year to date.

<table>
<thead>
<tr>
<th>Epidemiological Week</th>
<th>Number of Visits</th>
<th>Weekly Visits to Sentinel Sites for Fever and Neurological Symptoms 2019 vs. Weekly Threshold: Jamaica</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Epidemiological Week</th>
<th>Number of Visits</th>
<th>Weekly Visits to Sentinel Sites for Fever and Haemorrhagic 2019 vs Weekly Threshold; Jamaica</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Epidemiological Week</th>
<th>Number of Visits</th>
<th>Weekly visits to Sentinel Sites for Fever and Jaundice : Jamaica, Weekly Threshold vs Cases 2018 and 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACCIDENTS
Any injury for which the cause is unintentional, e.g. motor vehicle, falls, burns, etc.

KEY
VARIATIONS OF BLUE SHOW CURRENT WEEK

VIOLENCE
Any injury for which the cause is intentional, e.g. gunshot wounds, stab wounds, etc.

GASTROENTERITIS
Inflammation of the stomach and intestines, typically resulting from bacterial toxins or viral infection and causing vomiting and diarrhoea.

ACCIDENTS
Weekly visits to Sentinel Sites for Accidents by Age Group 2019 vs Weekly Threshold; Jamaica

VIOLENCE
Weekly visits to Sentinel Sites for Violence by Age Group 2019 vs Weekly Threshold; Jamaica

GASTROENTERITIS
Weekly visits to Sentinel Sites for Gastroenteritis All ages 2019 vs Weekly Threshold; Jamaica
## CLASS ONE NOTIFIABLE EVENTS

<table>
<thead>
<tr>
<th>CLASS 1 EVENTS</th>
<th>Confirmed YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NATIONAL / INTERNATIONAL INTEREST</strong></td>
<td></td>
</tr>
<tr>
<td>Accidental Poisoning</td>
<td>64</td>
</tr>
<tr>
<td>Cholera</td>
<td>0</td>
</tr>
<tr>
<td>Dengue Hemorrhagic Fever*</td>
<td>NA</td>
</tr>
<tr>
<td>Hansen’s Disease (Leprosy)</td>
<td>0</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>23</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>2</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>NA</td>
</tr>
<tr>
<td>Malaria (Imported)</td>
<td>0</td>
</tr>
<tr>
<td>Meningitis (Clinically confirmed)</td>
<td>20</td>
</tr>
<tr>
<td><strong>EXOTIC/ UNUSUAL</strong></td>
<td></td>
</tr>
<tr>
<td>Plague</td>
<td>0</td>
</tr>
<tr>
<td><strong>HIGH MORBIDITY/ MORTALITY</strong></td>
<td></td>
</tr>
<tr>
<td>Meningococcal Meningitis</td>
<td>0</td>
</tr>
<tr>
<td>Neonatal Tetanus</td>
<td>0</td>
</tr>
<tr>
<td>Typhoid Fever</td>
<td>0</td>
</tr>
<tr>
<td>Meningitis H/Flu</td>
<td>0</td>
</tr>
<tr>
<td>AFP/Polio</td>
<td>0</td>
</tr>
<tr>
<td>Congenital Rubella Syndrome</td>
<td>0</td>
</tr>
<tr>
<td>Congenital Syphilis</td>
<td>0</td>
</tr>
<tr>
<td>Fever and Rash</td>
<td>0</td>
</tr>
<tr>
<td>Measles</td>
<td>0</td>
</tr>
<tr>
<td>Rubella</td>
<td>0</td>
</tr>
<tr>
<td>Maternal Deaths**</td>
<td>55</td>
</tr>
<tr>
<td>Ophthalmia Neonatorum</td>
<td>222</td>
</tr>
<tr>
<td>Pertussis-like syndrome</td>
<td>0</td>
</tr>
<tr>
<td>Rheumatic Fever</td>
<td>0</td>
</tr>
<tr>
<td>Tetanus</td>
<td>0</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>54</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>0</td>
</tr>
<tr>
<td><strong>SPECIAL PROGRAMMES</strong></td>
<td></td>
</tr>
<tr>
<td>Chikungunya***</td>
<td>7</td>
</tr>
<tr>
<td>Zika Virus****</td>
<td>0</td>
</tr>
</tbody>
</table>

### Comments

- AFP Field Guides from WHO indicate that for an effective surveillance system, detection rates for AFP should be 1/100,000 population under 15 years old (6 to 7) cases annually.

- Pertussis-like syndrome and Tetanus are clinically confirmed classifications.

- * Dengue Hemorrhagic Fever data include Dengue related deaths;

- ** Figures include all deaths associated with pregnancy reported for the period.

- *** CHIKV IgM positive cases

- **** Zika PCR positive cases

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**NOTIFICATIONS**
- All clinical sites

**INVESTIGATION REPORTS**
- Detailed Follow up for all Class One Events

**HOSPITAL ACTIVE SURVEILLANCE**
- 30 sites. Actively pursued

**SENTINEL REPORT**
- 78 sites. Automatic reporting
**NOTIFICATIONS**

All clinical sites

**INVESTIGATION REPORTS**

Detailed Follow up for all Class One Events

**HOSPITAL ACTIVE SURVEILLANCE**

30 sites. Actively pursued

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78 sites. Automatic reporting

---

**NATIONAL SURVEILLANCE UNIT**

**INFLUENZA REPORT**

November 17 – November 23, 2019  Epidemiological Week 47

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**EW 47**

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### SARI cases

<table>
<thead>
<tr>
<th></th>
<th>EW 47</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SARI cases</td>
<td>9</td>
<td>483</td>
</tr>
<tr>
<td>Total Influenza positive Samples</td>
<td>12</td>
<td>458</td>
</tr>
<tr>
<td>Influenza A</td>
<td>12</td>
<td>415</td>
</tr>
<tr>
<td>H3N2</td>
<td>10</td>
<td>178</td>
</tr>
<tr>
<td>H1N1pdm09</td>
<td>0</td>
<td>226</td>
</tr>
<tr>
<td>Not subtyped</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Influenza B</td>
<td>0</td>
<td>43</td>
</tr>
<tr>
<td>Parainfluenza</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

**Epi Week Summary**

During EW 47, 12 cases of influenza were detected. Percent positivity is 48%.

During EW 47, 9 (nine) SARI admissions were reported.

**Caribbean Update EW 47**

Overall, influenza and SARI activity continued at low levels with influenza A(H3N2), A(H1N1)pdm09, and influenza B viruses co-circulating in the subregion. In Jamaica influenza activity continued increased with influenza A(H3N2) virus predominance and SARI cases at low levels. In Trinidad and Tobago, after a peak in EW 45, influenza activity began to decrease with influenza A(H1N1)pdm09 predominance and A(H3N2) co-circulating; SARI activity decreased but remained above the epidemic threshold.

---

**Weekly visits to Sentinel Sites for Influenza-like Illness (ILI)**

All ages 2019 vs Weekly Threshold; Jamaica

**Jamaica: Percentage of Hospital Admissions for Severe Acute Respiratory Illness (SARI 2019) (compared with 2011-2018)**

**Distribution of influenza and subtype**

---
Dengue Bulletin

November 17 – November 23, 2019  Epidemiological Week 47

Reported suspected and confirmed dengue with symptom onset in weeks 1-47 2019

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Suspected Dengue Cases</strong></td>
<td>0</td>
<td>6882</td>
</tr>
<tr>
<td><strong>Lab Confirmed Dengue cases</strong></td>
<td>0</td>
<td>60</td>
</tr>
<tr>
<td><strong>CONFIRMED Dengue Related Deaths</strong></td>
<td>0</td>
<td>15</td>
</tr>
</tbody>
</table>

*Figure as at November 28, 2019*

**Points to note:**

- Only PCR positive dengue cases are reported as confirmed.
- IgM positive cases are classified as presumed dengue.

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**Suspected dengue cases for 2018 and 2019 versus monthly mean, alert, and epidemic thresholds**

---

**Symptoms of Dengue fever**

- **Febrile phase**
  - sudden-onset fever
  - headache
  - mouth and nose bleeding
  - muscle and joint pains
- **Critical phase**
  - hypotension
  - pleural effusion
  - ascites
  - gastrointestinal bleeding
- **Recovery phase**
  - altered level of consciousness
  - seizures
  - itching
  - slow heart rate

---

**Graphs:**

- Dengue Cases by Year: 2004-2019, Jamaica
- Suspected Dengue cases for 2018 and 2019 versus monthly mean, alert, and epidemic thresholds
Title: Psychiatric Relapse and Hospital Readmissions: A Qualitative Study to Explore the Perspectives of Persons Living with Serious Mental Illness in Western Jamaica

Author: Debra Roof, Department of Psychiatry, Cornwall Regional Hospital, Western Region Mental Health Services
Email: debbiroof@yahoo.co.uk

Theme: Chronic Non-communicable diseases (mental health)

Abstract:

Objectives: To conduct a qualitative study that explores patients’ perspectives of the barriers and facilitators to recovery by:
Exploring accounts of what is helpful or unhelpful for persons in staying well and out of hospital through a set of face-to-face semi-structured interviews with a sample of outpatients frequently hospitalised.
Examining the overarching themes and shared experiences between patients by conducting a thematic analysis across the interview data.

Methods: A qualitative research methodology was used to investigate the perspectives of nine outpatients with a diagnosis of serious mental illness and frequent hospitalisation. Data collection was through face-to-face semi-structured interviews which explored the lived experience of staying well and out of hospital. Interviews were transcribed verbatim, data was manually coded and analysed using thematic analysis.
Findings: Six overarching themes: unmet basic needs, stopping medication, stress, marijuana use, influences of other people and physical effects were identified for the barriers to recovery. Five overarching themes: obtaining basic needs, taking medication, occupation, faith and the therapeutic aspect of the ward were the facilitators to recovery.

Conclusions: For this psychiatric setting there needs to be more concerted efforts to develop outpatient follow-up with psychosocial programmes that enhance rehabilitation and integrated care continuum for persons with mental illness. The importance of this study is that it provides a platform for patients living in Western Jamaica and gives insights into the lived experience. This has implications for therapists by building local knowledge and links to evidence-based practices that can improve patients’ treatment and recovery outcomes.